THE UNIVERSITY
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Integrated care in the UK and Australia

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At the request of the Royal Australian College of General Practitioners (RACGP), in December 1997 the Health Services Management Centre (HSMC) hosted a one-day seminar, chaired by Darrin Baines, on the implications of the UK's experience of fundholding, commissioning and integrated care for Australian general practice.

Presentations were given by leading policy analysts, public servants and general practitioners (GPs) from both the UK and Australia to an audience of invited participants, all of whom had an in-depth knowledge of purchasing, general practice and health care reform.

ISSUES FACING THE AUSTRALIAN HEALTH CARE SYSTEM

Michael Bollen provided a background to the seminar by outlining the issues facing Australian GPs today:

'Currently every aspect of Australian general practice is under scrutiny. In particular, the General Practice Strategy review groups, appointed by the Minister of Health, are examining the present system and are required to make recommendations for the future directions of: remuneration strategies; general practice management; possible and desirable improvements in the delivery of care; incentives to assist in retaining GPs in rural areas; ways of encourage GPs to utilise information technology.'

Michael Bollen stated that the key issues of interest from UK experience include:

- GP morale
- Constraints versus opportunities
- Relationships that have existed since fundholding between GPs and other health care providers
- What should someone with a medical degree be doing?
- Use of ethics and incentives
- What are the real issues behind the NHS White Paper[1] and what are the funding implications?

THE COMMONWEALTH'S PERSPECTIVE

Louise Morauta described the structure, challenges and future directions of the Australian health care system.

Australia is very similar to the UK in terms of national economic and health indicators. Health inequities in Australia are most visible for aboriginal groups, and these may be more pronounced than for minority groups in the UK. Health is a major concern for the Australian public and is always among the top three issues determining voting behaviour.

Whilst total Australian expenditure on health is 8.4% of GDP (and growing), government health outlays in Australia and the UK are similar at around 5.8%. This is reflected in Australia's mixed health care system, where Medicare constitutes 67% of total health expenditure; with another 15% coming from private health insurance and the remaining 18% being out-of-pocket (mainly pharmaceuticals) expenditure.

The Medicare system rebates 85% of schedule fees for private medical services/primary care, 75% for private hospital services and 100% for public hospital services; it also subsidises the cost of pharmaceuticals (although the prescription charge is twice that of the UK). Australia has some 20,000 GPs, about 1 per 800 population, with 30% in solo practices. 96% of GP income is derived on a fee-for-service basis.

The Commonwealth's 1992/93 GP strategy had four main components:

- introduction of programmes to attract GPs to rural areas;
- establishment of Divisions of General Practice;
- implementation of a practice accreditation system;
- development of the Better Practice Program.

Currently, it is planned that 1998 will see the following new initiatives in Australian general practice:

- first pure outcomes payment for GPs (for immunisation rates in 0-6 year olds);
- evidence-based approach to Medical Benefits Schedule to scrutinise new procedures;
- National Prescribing Service, with financial incentives to encourage effective prescribing;
- two reviews of GP programmes;
- Coordinated Care Trials.

The Coordinated Care Trials (CCTs) are trials of integrated care for people with complex and chronic health problems. There is a pooled budget of Commonwealth and State funds for hospital and community services. Each patient has a care co-ordinator and an individual care plan. The CCT budget is $140m (72% from State Government) for 9 trials in 5 states. The budget includes $3m (from Commonwealth Government) for national and local trial evaluations based on the 17,000 people covered and 9000 controls. CCTs do not represent a 'hard' capped budget, but rather a 'soft' budget system where providers and funders share the risks of budget overspends. The main expected benefit is a change in service delivery, with reduced use of hospital services and increased use of community services. GP guidelines preserve patients' rights over GP choice, ensure GP control of clinical decision-making, confirm GP's role as care coordinator for primarily medical conditions and ensure that no patients can be excluded on the basis of service use. The various trials have different target groups, although all relate to high end users.

CCTs illustrate the Commonwealth's preferred approach to health reform:

- gradualist, bottom-up, incremental approach, with a focus on health outcomes;
- use of best practice and evidence-based medicine to move the system forwards;
- driven from health portfolios, avoiding capped budgets and focusing on development through health improvements rather than financial restrictions.

Speakers

Dr Michael Bollen, Secretary General, RACGP
Dr Louise Morauta, First Assistant Secretary, Health Benefits Division, Commonwealth Dept. of Health and Family Services
Professor Chris Ham, Director, HSMC, University of Birmingham
Dr Jonathan Shapiro, Senior Research Fellow, HSMC, University of Birmingham
Professor James Raftery, Director, Health Economics Facility, HSMC, University of Birmingham
Judith Smith, Fellow, HSMC, University of Birmingham
Dr Stephen Earwicker, General Practitioner and Secretary, Nottingham Local Medical Committee

THE UK EXPERIENCE

Chris Ham discussed developments and changes to UK general practice under the Conservative's health reforms and the Labour government's recent White Paper.

The NHS reforms and changes to general practice introduced during the early 1990s shifted the balance to primary care and led to the emergence of new types of primary care organisations, for example, fundholding practices, multifunds, commissioning groups, out-of-hours cooperatives and Total Purchasing Pilots (TPPs).

As shown by recent HSMC work in the West Midlands, developments are taking us beyond fundholding into primary care provision, as well as primary care commissioning.[2] We can see many features of the American system of HMOs in these primary care structures, especially in the TPPs. This opens up the possibility of multi-specialty groups in general practice, bridging the traditional divides in UK medicine. We could see specialists like paediatricians, geriatricians, gynaecologists and physicians working alongside GPs and practice nurses, with GPs also developing their own specialist skills.

The challenge for the government is how to address inequalities and increase standards at the bottom, whilst supporting the innovators. The focus on poor quality is welcome, but GPs at the leading edge must also be encouraged. The government's education policy may provide an insight into future health policy: emphasis on standards in the classroom; supported by training and development for staff. Indeed, there may be a role for health authorities in setting, monitoring and improving standards, primary care development, working with Trusts and primary care professionals, and protecting patients' interests.

The White Paper agenda and the theme of Integrated Care

The intention is that Community Health Services Trusts and new models of general practice will come together into Primary Health Care Trusts (PHCTs), and that we will see the integration of provision and commissioning. The power of PHCTs can then be used to build integration between PHCTs and acute Trusts. We may also see closer integration between NHS and Local Authority services. So a possible future could be one of patient choice of capitation-funded PHCTs, which both provide services and commission from hospitals and specialist staff.

There are parallels with international experience. Developments in both California and New Zealand are leading to the establishment of organisations of primary care physicians known as independent practice associations (IPAs). In turn, IPAs are forming alliances with hospitals. The emerging models of vertical integration and virtual integration[3] indicate the shape of things to come for the UK and echo developments in Australia with the Coordinated Care Trials.

The main points are:

- Starting from a strong base;
- Challenge to balance innovation and the focus on increasing standards;
- Important to remember that the majority of GPs are neither innovators nor of poor quality.

APPROACHES TO PURCHASING, COMMISSIONING AND INTEGRATED CARE

Jonathan Shapiro argued that patient pathways are better descriptions of the structure of health care provision than a division into 'primary' and 'secondary' care.

The generic shape of health care services in the UK runs along a pathway from the centre to health authorities to GPs to technical service providers. Within this structure, GPs have four main roles: (1) provision of care; (2) procurement of care; (3) co-ordination of care and records; and (4) interpretation.

Health service issues of the 1990s are the same as always: growing demand; a society pro-choice but anti-tax; increasing costs; and a system dominated by acute hospitals good at shroud waving.

We need now to recognise the successful changes from the last eight years, which include:

- first steps towards linking activity and costs;
- increased resource awareness;
- somewhat better balance of power between GPs and consultants;
- focus on primary care provision;
- enhanced local sensitivity;
- devolved responsibility, which builds in unaccountability which is useful in a period of change;
- somewhat reduced inter-agency collusion;
- Trusts have been made more responsive.

However, some of the costs have been:

- the managed market: 'privoid' Trusts, aggressive fundholders, expensive devolution, unsustainability of different funding streams;
- GPs having to accept the loss to their own patients for the greater gain, which is necessary if we are to have cost-effective treatments and equity;
- patchy delivery and impossible overall strategy;
- too medically driven;
- domination of acute hospitals, where threat of removal of main contracts by health authorities is not credible and threat of removal of fundholders' contracts inconsequential.

In replacing the internal market, we need to consider the need for leverage (i.e., how to effect change). Leverage requires professional ownership, as service development depends totally on the professionals involved, and probably also some form of contracts. Local sensitivity is useful as it links Departments of Public Health to real public health, fits in with consumerism and provides local solutions to local problems. However, to be useful local sensitivity must also share operational tasks, make management easier and reduce risks.

With the push for an integrated approach, we are seeing a move back to clinical management in response to the failure of purely financial mechanisms. The perceived split between clinicians and managers is unfortunate as both are required and their skills are complementary.

The new agenda seems to put GPs forward as providers of care, and switches the traditional spectrum of care to a system where the 'front door' is changing. Concerns are less about who is providing first-contact services than about how well these services are being provided.

There is no one correct model for a health service. The lesson is rather to set down principles and let the structure follow. Corporacy is the key to the success of the new NHS. Health authority roles are regulation, development, change management, networks and intelligence, coordination and operational functions. The roles of the Primary Care Groups will be to develop corporacy, protocols and peer support, feed into strategic policy making in advisory or executive roles with health authorities, and deliver services to all stakeholders.

THE EFFECTS OF TOTAL FUNDHOLDING

James Raftery discussed the effects of Total Fundholding using evidence from the TPP pilot sites.

In 1994/5 four pioneer TPPs, built on fundholding, received a full hospital and community health services budget. In doing so, the first effect of the TPP exercise was GP realisation of what health authorities actually pay for. 53 first-wave TPPs were set up in 1995/6. These were delegated the total budget and had the scope to pass back chunks of this to the governing Health Authority. The first-wave TPPs were very diverse in structure: 16 were single-practice groups, all were self-selected and most were outside of the big urban regions (often in better-off areas).

Only two TPPs 'went live' in 1995/6. Half had difficulty agreeing budgets in 1996/7 (which was predictable given the changing national capitation formulae) and only half of the remainder contracted independently. By 1996/7, no TPP purchased all services. There were a range of arrangements with health authorities, from fully blocked-back budgets to co-purchasing and independent purchasing.

The evaluation of TPPs was summative, although a formative approach would have been better (i.e. to have ongoing feedback to the TPPs). Interviews with GPs reported success of TPPs but this was often in intangible areas or around the ability to increase practice staff numbers. Routine data on hospital episodes showed no change in the number of admissions but a sharp decline in length of stay for those TPPs that targeted this. However, TPPs experienced problems in realising savings from reduced length of hospital stay, as marginal cost savings from the Trusts resulted in rising prices for other Trust services and no overall savings.

Characteristics associated with success were other than those expected. Success was expected in large projects with dedicated managers, but the evaluation found that single-practice TPPs did better in terms of both tangible and intangible outcomes. We need now to know whether this is a temporary or permanent effect, and to know what impacts are due to GPs working together.

Several implications for GP commissioning can be drawn from the TPP experience:

- it is essential to sort out budget-setting methods;

- slow start-up is likely;
- there are major issues around getting practices to work together;
- these types of initiative can be difficult to evaluate.

A NATIONAL SURVEY OF COMMISSIONING MODELS

Judith Smith reported on the results of a national survey of commissioning models in English health authorities,[4] which was based on a study of models of commissioning in the West Midlands.[2]

The taxonomy developed in the study identified 6 main commissioning approaches:

- GP multifund;
- fundholding consortium;
- locality commissioning;
- commissioning based on groups of practices;
- authority-wide GP group;
- others: joint commissioning with social services; 'health alliances' with local authorities; client or specialty focused approaches (e.g. children's health services, respiratory diseases); area-based approaches; provider-based groups (community hospital or larger).

In terms of the number of different categories found, 84% of HAs had between two and four different approaches; 8% had just one and 8% had five or six. 34 health authorities had GP multifunds; 57 had fundholding consortia; 60 had locality commissioning; 36 had group practice-based commissioning; 69 had an authority-wide group; and 35 had 'other'.

Many of the different approaches were inclusive of both fundholding and non-fundholding practices and multiple membership was common, with one practice often being part of more than one different commissioning group. The importance lies in combining the strengths of the different approaches:

- locality commissioning, commissioning based on groups of practices and Authority-wide groups most often involved other stakeholders;
- locality commissioning and authority-wide groups were most often reported as having strong strategic commissioning functions, whilst GP multifunds and fundholding consortia were more often cited for strong implementation commissioning functions;
- GP multifunds were most often felt to have a positive impact on prescribing;
- more than half of all health authorities felt that all the commissioning approaches had had a positive impact on extending primary care services, with GP multifunds rated highest;
- GP multifunds were also most often reported as having had a positive impact on referral practice;
- locality commissioning groups were most frequently cited as having had a beneficial impact on service quality; GP multifunds were least often cited here;
- locality commissioning and authority-wide groups were most frequently reported as having had a beneficial impact on emergency admissions, although overall levels of impact were low;
- a detrimental effect on services for the chronically and mentally ill was reported by seven health authorities; locality commissioning and authority-wide groups were again most cited as having a beneficial impact here, although overall levels of impact were low;
- locality commissioning was seen as most beneficial in terms of the health authorities own capacity to assess needs and to consult with the public;
- all groups were seen as having a positive impact on the Health Authority's capacity to ensure more responsive services.

In summary, no single approach performs consistently well. Therefore we need a range of levers and approaches to promote all the potential benefits of primary care commissioning. In terms of response, the government's White Paper seems to have accepted the need for local flexibility and has moved to integrate the commissioning and provision of services. Primary Care Groups will evolve from existing commissioning approaches, but will exist within clearer accountability and strategic management frameworks.

THE NOTTINGHAM EXPERIENCE

Stephen Earwicker described his experience of GP commissioning in Nottingham. A Total Commissioning Pilot has been established in Nottingham, covering 89% of the Health Authority's 633,000 population and 290 of the 327 existing GPs (including 59 of the Authority's 87 existing fundholding GPs).

The Nottingham commissioning group model consists of a commissioning team of 16 GPs and a project board of four GPs and four Health Authority executives. It has a cash-limited prescribing budget, which was the key difference for non-fundholding practices joining the scheme. There are four programmes of care and additional special projects in IT, information and prescribing. The project has the full commitment of the health authority Chief Executive, who is ultimately responsible for the success of the project. Both fundholding and non-fundholding GPs are involved, although there has historically been animosity between these groups. Key positions within the group also tend to be biased towards academic GPs and/or medical politicians.

There are several potential areas of conflict between the Health Authority and GPs:

- fundholding;
- rationing of secondary care;
- cash-limiting of primary care;
- guidelines and protocols;
- managing failing practices;
- following NHS Executive guidelines;
- local sensitivity.

The historically low level of GP prescribing costs in Nottingham (at around 8% below the national average) also presents a problem in terms of the ability of the group to quickly show success. Fears for the future relate to: the cash-limited prescribing budget; problems caused by having some patients waiting 18-months for treatment; hospital deficits; handling equity/efficiency trade-offs; rationing; levers for change; and lack of clarity over where the power lies within the group itself.

Lessons from the Nottingham model concern the importance of 'taking the troops with you', of getting all GPs to follow in the steps of the innovators. Mechanisms in the Nottingham model for this include:

- constituency, communication and education: there is a regular newsletter and the 16 lead GPs each have a set of GPs to look after, inform, etc.
- incentives (which are especially important for achieving on prescribing targets), including the altruistic incentives that if you save on prescribing, you have more to spend on secondary care, and at the individual practice level, incentives in the form of money to spend on the practice if you achieve prescribing targets, generic standards, etc.
- delivering the goods: the group needs to deliver something over the trial three-year period, so choice of targets is driven by the short-term need for visible results

IMPLICATIONS FOR AUSTRALIA

Michael Bollen drew together the main themes from the UK experience and outlined the following questions for future directions in Australian general practice:

1. What is the appropriate use of quality measures for consultations, medicines and referrals?
2. What is the level of consumer involvement and satisfaction in the UK now?
3. How should change be managed, especially when some people (innovators) are running ahead with new initiatives and others are taking a 'wait and see' attitude?
4. How can enthusiasm be maintained?
5. How should vested interests be dealt with? How should we deal with coalitions?
6. What are the drivers for: cost-containment; incentives; meeting the wants and needs of GPs, the health system, the public and medical organisations?
7. How do you we get health care organisations to move forward?
8. How do we sustain change?
9. Does the UK experience have any lessons for structuring the interface between primary care and government or the consumer?
10. What is the possibility of GP-consumer relationships moving governments, rather than the other way around?
11. If appropriate care means higher primary care costs and lower secondary care, where can the savings be made?

RESPONSES FROM PARTICIPANTS

In response to the above questions, participants discussed the relevance of the UK experience for Australian general practice and raised the following points:

International trends

Firstly, we are seeing some common trends world-wide, not just in the UK and Australia:

- a retreat from the love affair with markets
- changes that are taking us back to a primary care focus, stressing integration and incrementalism, rather than a 'big bang' approach to change, with more humility from politicians in terms of what big change can actually achieve
- pragmatic problem solving
- trying to keep Treasury away from health care

There are lots of similarities between the Australian health care system and the NHS. The Divisions of General Practice are very similar to Primary Health Care Trusts. There is a shared emphasis on evidence and effectiveness. The gradualist, bottom-up pace of change is similar.

Incentives

Incentives will be critical in Australia, as GPs must see benefits in expending the time and effort that is inevitably involved in change. The incentives that exist in Australia at the moment are quite strong, especially in terms of fee-for-service mechanisms, but we need to examine whether these are working in the way in which we want them to, and to be prepared to rearrange them if not.

Quality measurement

In the UK we are seeing the development of local primary health care outcome indicators. Fundholders have also been increasingly analysing their own referral patterns and other activity as a basis for change that will allow better patient care, an ability to reinvest savings in other areas and create the opportunity to be innovative. In Australia, the new initiatives in Brisbane and elsewhere also have an interest in collecting routine data which is primary-care sensitive.

GP numbers, abilities and organisation

Australia has a high number of GPs compared to the UK, but to address the question of how many GPs you need, you must address the question of what are GPs for, what do people want them to do, and what are the essential roles of a GP compared to other primary health care professionals. We may be too medically oriented, and need to think beyond the traditional box, to how practice nurses and other health professionals may be used to best advantage. Sustainability requires GPs to have the ability to delegate, especially to professionals who are better placed to deal with certain activities (community nurses, practice nurses, psychiatrists, etc.).

Innovative GPs

Innovators have been crucial to the success of UK primary care initiatives, but as initiatives become commonplace we expect to see GP innovators move on. Currently, we see those taking initiatives as being motivated by the feeling of empowerment as well as the thrill of the chase, but how can this be sustained? Whilst success itself can sustain enthusiasm, we do not expect innovators to remain in an area once it has become commonplace. The UK has been through the first stage of letting GP innovators run with ideas without trying to control them. We are now at the stage of being able to see what works.

Purchasing and commissioning

Total Purchasing is definitely a recognition of the success of some fundholders; but it may also be seen as a recognition that fundholding as a concept has been dead for some time. Another point of view is that the 'big bang' introduction of fundholding was a necessary act for the current diversity to develop. The new government and initiatives are essentially moving towards the same diversity of commissioning as currently exists. One difference is that this time around it is against the background of an emphasis on a "fair share of resources", whether you are opting in or out of commissioning groups, rather than the biasing of resources towards fundholding practices.

GP involvement and skills

In the UK, evidence suggests that early wave fundholders were more able to control their prescribing costs than their non-fundholding counterparts.[5] Moreover, the first-wave fundholders were enthusiastic individuals, often hospital-linked and/or with specialist skills. GPs tended to develop skills that they already had and/or to build up new skills from partners within the practice. This led to an improvement in communication within practices, which may not have been there before. In Australia, there are many GPs interested in systemic reform. The empowerment of such people is important and reskilling may be an important part of the process.

Role of consumers

In Australia, the public like the health system the way it is and don't want to see change. In the UK, there is a consistent finding that people are much happier with primary care than they are with acute sector care or with the NHS overall, so the big push for changes to general practice is from Treasury (especially over prescribing) and from the more general push towards increasing effectiveness, value for money and quality in public services. A second push factor comes from problems over morale and low recruitment.

Continuity of care

Issues of continuity of care and registered lists are important to Australia, but it can be argued that it is health care professionals rather than patients that stand to benefit from these. Continuity of care relates to the level of a practice, rather than of an individual GP. This may be important for Australia which has a higher level of single-handed practices. If Australia wants to reduce its single-handed practices, it could follow the NHS approach of incentives (group practice payments, capital grants, etc.). However, the fact that health insurance funding is only paid for services provided by a medically registered person (and therefore not a practice nurse of other health professional) limits the number of staff a practice can have and limits patient choice.

Health service reforms

Changing health care system structures requires change in medical training and attitudes. Attitudes in the NHS have changed a lot over the last 10 years, but change does take time. Given the time taken to recover support after the 'big bang' reforms of early 1990s and the knowledge that health care professionals get tired of continual change, an incremental approach is welcomed.

Political management and systems

In Australia, it is difficult to imagine a similar lack of outcry to cash-limited general practice as proposed by the NHS White Paper. There are concerns about this in the UK, although fundholding has got people in primary care used to the idea of cash limits. Also the White Paper was launched with the slick political management typical of the new Labour administration.

Finally, the political structure may present greater problems for health care reform in Australia than faced in the UK. With an election every three years, it may be difficult for any Australian government to achieve substantial gains within one term if an incremental approach to reform is employed. Additional problems may arise when different political parties are in control of Senate and of the House of Representatives.

REFERENCES

1 Department of Health. (1997). The new NHS: Modern, Dependable. London: HMSO

2 Smith, J., Bamford, M., Ham, C., Scrivens, E. and Shapiro, J. (1997) 'Beyond fundholding: a mosaic of primary care led commissioning and provision in the West Midlands', HSMC University of Birmingham and CHPM Keele University

3 Robinson, J.C. and Cosolino, C.P. (1996). 'Vertical integration and organisational networks in health care', Health Affairs, Vol. 15, No. 1, pp.7-22.

4 Smith, J., Barnes, M., Ham, C. and Martin, G. (in press). Mapping approaches to commissioning: extending the mosaic. London: King's Fund.

5 Baines, D. L., Tolley, K. H and Whynes, D. K. (1997). Prescribing, budgets and fundholding in general practice. London: Office of Health Economics.

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